Letters to the Editor

The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should:

- Include no more than 500 words of text, three authors, and five references
- Type with double-spacing
- See http://jtcs.ctsnetjournals.org/misc/ifora.shtml for detailed submission instructions.
- Submit the letter electronically via jtcvs.editorialmanager.com.

Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity of offer a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.

Stentless valve dehiscence

To the Editor:

With great interest we read the article by Richard Hopkins and colleagues[1] on their patient who experienced dehiscence of the preserved noncoronary sinus after subcoronary allograft replacement of the aortic valve. The authors write that this complication might not be unique for this method of allograft implantation and that it could in fact occur with any type of inclusion technique, as long as sinuses are retained. They also suggest that some methods of insertion of stentless xenograft valves could also be liable to this complication.

We can confirm that dehiscence of the stentless xenograft indeed occurs and that it has a strong predilection for the noncoronary sinus. In 10 of 168 patients, partial dehiscence was found 4 to 49 months after subcoronary implantation of a stentless xenograft with preserved noncoronary sinus.[2] In contrast to the reported patient, our patients all received diagnoses relatively early and all underwent reoperations for present or feared valve dysfunction. The mechanism, however, seems similar. Supposedly, proteolytic enzymes from captured blood cells in the dead space between native and donor aortas might prevent adequate fusion of the walls and healing of the anastomosis.

The assumption that this particular problem is related to the concept of coronary sinus inclusion seems very likely, and closure of the dead space might be important when this particular technique is used.

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References

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2. Schoof P, Baur L, Kappetein A, Hazekamp M, vanRijk-Zwikker G, Huysmans H. Dehiscence of the Freestyle stentless bioprosthesis. *Semin Thorac Cardiovasc Surg*. 1999;11(suppl 1): 133-8.

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Reply to the Editor:

We appreciate Professor Schoof and his colleagues for confirming our observations concerning the technical predilections for this complication. We use the stentless xenograft as an aortic root replacement, and therefore we have no experience with techniques liable to this complication, except historically with homografts. The 6% incidence in their series with an inclusion technique retaining 1 or more sinuses is indeed concerning. We concur that meticulous attention to closure of the dead space between the native and implanted sinus walls is critical. When we were using the "scallop" technique, we did use obliterating sutures, which clearly did not obviate this single occurrence. We can only speculate about the potential usefulness of biologic glues to enhance fusion of the walls. In contrast to their 100% reoperation rate, our single case report was also written to make the point that in the absence of valve dysfunction, progressive dehiscence, or the development of thrombus, conservative management appears to be safe with antiplatelet therapy and consistent yearly imaging follow-up.

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Management of postintubation tracheal ruptures

To the Editor:

We read with interest the article by Park and colleagues,[1] who described a new approach for the intraluminal repair of membranous tracheal rupture (TR) after emergency intubation. We congratulate them for their result in an elderly patient in poor condition.

The authors discussed the value of the different approaches to surgical treatment